MICHAEL W. BAIN MD

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AUTHORIZATION TO RELEASE PSYCHIATRIC INFORMATION

Date _____

Patient Name: _____

Patient Date of Birth: _____

I authorize Michael W. Bain MD to release to:

_____
_____
_____
_____

_____ report of psychiatric evaluation and treatment

_____ complete medical/psychiatric records

_____ other (specify)

_____

I release Dr. Bain from all legal responsibility or liability that may arise from this authorization. This authorization expires on _____, or earlier if I so specify in writing.

Patient signature: _____

Parent signature: _____
(or legal guardian/custodian if patient is a minor)